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No. 82-1031

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE; BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

RICHARD L. EPSTEIN
ROBERT W. MCCANN
LINDA A. TOMASELLI
840 North Lake Shore Drive
Chicago, Illinois 60611
Attorneys for Amicus Curiae
American Hospital Association

Of Counsel:
H. ROBERT HALPER
JOHN J. MILES
O'CONNOR & HANNAN
1919 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
LAWRENCE A. MANSON
WOOD, LUCKSINGER & EPSTEIN
444 North Michigan Avenue
Chicago, Illinois 60611

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QUESTION PRESENTED

Whether an arrangement by which a hospital chooses only one group of physicians to render all anesthesia services at the hospital is a *per se* illegal tying arrangement under Section 1 of the Sherman Act, 15 U. S. C. § 1 (1976).

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

The American Hospital Association respectfully moves for leave to file the attached brief *amicus curiae* in support of the Petitioners' request that a writ of certiorari issue to the United States Court of Appeals for the Fifth Circuit. The consent of counsel for the Petitioners to the filing of a brief *amicus curiae* by the American Hospital Association has been obtained. The consent of counsel for the Respondent has been requested but refused.

The interest of the American Hospital Association in this matter arises from its being the primary organization of hospitals in the United States. Its membership includes approximately 6,300 hospitals and other health care institutions, a large number of which nationwide provide anesthesiology services to their patients pursuant to an exclusive arrangement with physicians of the type under scrutiny in this case. As the national

spokesman for the hospital industry, the American Hospital Association is in a unique position to represent the interests of hospitals throughout the United States which are not parties to this action but whose interests will be affected directly by the ultimate resolution of the issue presented herein and whose vital professional staffing decisions are and will remain subject to considerable uncertainty unless this Honorable Court resolves the current conflict among the decisions of the United States Courts of Appeals.

Respectfully submitted,

RICHARD L. EPSTEIN
ROBERT W. MCCANN
LINDA A. TOMASELLI
840 North Lake Shore Drive
Chicago, Illinois 60611
Attorneys for Amicus Curiae
American Hospital Association

Of Counsel:
H. ROBERT HALPER
JOHN J. MILES
O'CONNOR & HANNAN
1919 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
LAWRENCE A. MANSON
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444 North Michigan Avenue
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BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

Amicus Curiae American Hospital Association respectfully presents this brief in support of the Petitioners' request that a writ of certiorari issue from this Court to review the judgment of the United States Court of Appeals for the Fifth Circuit in the above-entitled matter.

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. It is a not-for-profit membership corporation organized under the laws of the State of Illinois. The principal corporate objective of the AHA is "to promote the welfare of the public through its leadership and its assistance to its members in the provision of

better health services for all people." The AHA has a federal income tax exemption under the provisions of Section 501(c)(6) of the Internal Revenue Code. Its membership includes approximately 6,300 hospitals and other health care institutions, as well as approximately 35,000 individuals.

The AHA has an historical commitment to the principle of quality health care for hospital patients, while recognizing that the containment of hospital costs is vital to the continued provision of that quality care by hospitals. Hence, the AHA traditionally has undertaken to assist its members in their efforts to achieve the delivery of cost-effective, high quality health care services. Because a hospital itself obviously is not a practitioner of medicine, its relationships with physicians are of critical importance to its success in achieving that goal, and to the ability of the hospital's governing board to discharge its own ultimate responsibility — imposed by federal Medicare program participation requirements, by voluntary accreditation standards, and, increasingly, by common law — for the composition and services of its medical staff.

The AHA recognizes that good medical care is being provided in hospitals by physicians under many different types of staffing arrangements and does not recommend or endorse any specific arrangement as the best means in all circumstances to provide hospital or medical services. *See* American Hospital Association, *Guidelines: Contractual Relationships Between Hospitals and Physicians* (1976). However, many of AHA's member hospitals, in the exercise of their professional judgment, maintain exclusive arrangements with physicians as a means to ensure twenty-four hour physician availability for provision of the subject service, to monitor most effectively the quality of health care services provided, to secure administrative services necessary to the most effective and efficient provision of the subject service, to enhance their ability to attract highly skilled physicians to their staffs, and to lower operating costs and thus to help restrain the rate of increase of

hospital costs. Such arrangements are particularly prevalent with respect to the provision of necessary, "ancillary" hospital services—anesthesiology, radiology, pathology and emergency room services—for the availability and quality of which hospitals bear an independent and judicially-recognized accountability to their patients. The AHA further believes that an exclusive arrangement of the type at issue in this case not only can serve the above-described important interests of the hospital and the community, and confer significant benefits on patients, but also actually serves to foster rather than inhibit competition in the health care marketplace. Consequently, the AHA strongly supports the right of hospitals to maintain the flexibility to enter into an exclusive arrangement with a physician or physician group if the hospital determines that such a staffing arrangement best allows it to serve the interests of its patients.

This brief is submitted in the hope that it will assist the Court in deciding to issue a writ of certiorari in this case and to rule on the important issue presented herein.

SUMMARY OF THE ARGUMENT

Amicus Curiae AHA respectfully submits that the Petitioners' request that this Court issue a writ of certiorari to the United States Court of Appeals for the Fifth Circuit should be granted for several reasons. First, the decision below creates a conflict among the United States Courts of Appeals with respect to both the lawfulness of exclusive arrangements under the antitrust laws and the appropriate standard of analysis, the Rule of Reason or the *per se* rule, to be applied. Second, the analysis of the Fifth Circuit's decision directly calls into question the validity of exclusive arrangements for the provision of medical services in addition to anesthesia. It thus creates profound uncertainty for numerous hospitals with respect to use of a staffing arrangement which can be critical to their ability to provide cost-effective, quality patient care. Third, the decision below conflicts with previous decisions of this Court with respect to the circumstances in which the *per se* standard of analysis should apply. Fourth, the Fifth Circuit erred in finding that the arrangement at issue is a tying arrangement, in that only one product—surgical services—actually is being sold. Finally, because the hospital lacked sufficient market power in the purported tying service to "leverage" itself in the tied service market, the Fifth Circuit erred in finding a *per se* violation of Section 1 of the Sherman Act.

REASONS FOR GRANTING THE PETITION

I. Conflict Among the Circuits

The United States Court of Appeals for the Fifth Circuit held that the exclusive arrangement at issue herein establishes a tying arrangement *per se* violative of Section 1 of the Sherman Act. 686 F. 2d 286 (5th Cir. 1982). The decision below thus made *per se* illegal what the district court found is a "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians. . . ." 513 F. Supp. 532, 540

(E.D. La. 1981). *See also Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center,* 684 F. 2d 1346, 1351 (7th Cir. 1982) ("exclusive dealing arrangement[s] ... [have] been adopted by most hospitals in the Chicago area").

It is particularly noteworthy, however, that every other federal court which has considered an exclusive arrangement has analyzed it under the Rule of Reason, and no federal court other than the Fifth Circuit in the instant case has found a violation of the Sherman Act. Those courts also have rejected all previous attempts to attach the *per se* label to an arrangement consistently found reasonable after appropriate analysis of its effects. *See Dos Santos,* 684 F. 2d at 1352 (rejecting argument that exclusive arrangement shown to constitute group boycott or other *per se* violation); *Smith* v. *Northern Michigan Hospitals, Inc.,* 518 F. Supp. 644 (W. D. Mich. 1981) (awarding summary judgment for defendant-hospital in action challenging exclusive contract for staffing of emergency room as, *inter alia,* refusal to deal). *See also Valley Hospital Medical Center Foundation* v. *Adolph,* No. 79-3336 MRP (C. D. Cal. Mar. 2, 1981).

With respect specifically to the several United States Courts of Appeals, the decision below has created a conflict among the decisions of the Fourth, Fifth and Seventh Circuits as to both the lawfulness of such arrangements and the analysis to be applied in judging their validity.

In *Harron* v. *United Hospital Center, Inc.,* 522 F. 2d 1133 (4th Cir. 1975), *cert. denied,* 424 U. S. 916 (1976), the Fourth Circuit considered a challenge under Section 1 of the Sherman Act to the hospital's exclusive contractual arrangement with an individual physician for the provision of all radiology services at the hospital. On appeal, the court of appeals found the plaintiff's Section 1 challenge to be "frivolous," reversed the district court's granting of a preliminary injunction against the hospital, and remanded the case with instructions that the

district court dismiss the complaint "for want of a substantial federal question and a consequent lack of jurisdiction." *Id.* at 1134. *See also Capili* v. *Shott,* 487 F. Supp. 710 (S. D. W. Va. 1978), *aff'd,* 620 F. 2d 438 (4th Cir. 1980) (challenge to exclusive arrangement for provision of anesthesia services failed to show effect on interstate commerce; arrangement also was neither unreasonable nor arbitrary).

The Seventh Circuit Court of Appeals, in *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center,* 684 F. 2d 1346 (7th Cir. 1982), vacated a preliminary injunction entered in favor of a plaintiff-physician who had challenged under Section 1 of the Sherman Act an exclusive contractual arrangement for the provision of anesthesia services. Most significantly, the court of appeals rejected an argument that the exclusive arrangement amounted to a group boycott or other *per se* violation, concluding instead that the case was "properly treated . . . as one involving a vertical combination . . . [which] . . . must be analyzed under the Rule of Reason." *Id.* at 1352, *citing, e.g., Tampa Electric Co.* v. *Nashville Coal Co.,* 365 U. S. 320 (1961).

Further, in concluding that it had "serious question whether plaintiff . . . demonstrated a reasonable likelihood of success on the merits," the Seventh Circuit adopted for purposes of its analysis the reasoning of the *district* court in the instant case, noting with "particular interest" that court's conclusion as to the relevant geographic market and its findings concerning the procompetitive effects of exclusive contracts. 684 F. 2d at 1353-54. Finally, the Seventh Circuit specifically instructed that the district court at trial should consider whether—in light of the fact, *inter alia,* that the patient generally takes no part in the selection of a particular anesthesiologist, that the expense to the patient of anesthesia services ordinarily is at least partially insured or otherwise payable by a third party, and that the hospital itself bears a legal responsibility for the availability and quality of anesthesia services rendered—it may be more

appropriate for antitrust purposes to treat the *hospital* rather than the patient as the purchaser of anesthesia services. *Id.* at 1354. Treatment of the hospital as the purchaser of the services would make impossible a finding that the exclusive arrangement at issue herein establishes a tying arrangement.

Thus, decisions of the Fourth and, in particular, the Seventh Circuit Courts of Appeals stand in stark contrast to that of the Fifth Circuit below and demonstrate as well that, with respect to exclusive arrangements for the provision of medical services, the nature of certain crucial economic relationships, assumed by the Fifth Circuit, remains far from clear.

Finally, it must be observed that the analysis of the Fifth Circuit below conflicts with decisions of the Third and Sixth Circuits, which, although involving staffing arrangements not exclusive in nature, raised similar antitrust issues, and in which Rule of Reason analysis was deemed appropriate. *See Stella* v. *Mercy Hospital,* No. 82-1274 (6th Cir. Oct. 25, 1982); *Robinson* v. *Magovern,* 521 F. Supp. 842 (W. D. Pa. 1981), *aff'd mem.,* 688 F. 2d 824 (3d Cir.), *cert. denied,* 103 S. Ct. 302 (1982). *See also Pontius* v. *Children's Hospital,* No. 78-987 (W. D. Pa. Dec. 20, 1982); *Pao* v. *Holy Redeemer Hospital,* 547 F. Supp. 484 (E. D. Pa. 1982).

II. Importance of the Issue Within the Hospital Field

a. In General

As recognized by courts that have considered exclusive arrangements of the type at issue herein, the use of such arrangements is widespread within the hospital field. *E.g., Dos Santos,* 684 F. 2d at 1351. Their increasing prevalence reflects both growing specialization and increasing sophistication in the delivery of medical services, as well as the ability of the arrangements to address important needs with respect to the delivery of such services. Specifically, exclusive arrangements allow hospitals to secure and maintain continuously available,

high quality medical services, to secure administrative services necessary to the effective and efficient operation of the subject department, and to lower the hospital's operating costs.

Hospitals today utilize contractual arrangements, many exclusive in nature, to ensure the provision of an increasing number of medical specialty services including, among others, nuclear medicine, renal dialysis and cardiac catheterization. However, the use of exclusive arrangements is especially prevalent nationwide with respect to the provision of hospital-based ancillary services —anesthesiology, radiology, pathology and emergency room services. As their name implies, ancillary services are provided in support of the primary service for which the patient is in the hospital. For example, anesthesia is one of the many services that are essential but 'ancillary' to the provision of the surgical services for which the patient has been admitted, and thus is viewed by most patients as part of the "hospitalization package." Patients in fact do not choose the ancillary care physicians who will provide those necessary services. *See Dos Santos,* 684 F. 2d at 1354; *United States* v. *American Society of Anesthesiologists,* 473 F. Supp. 147, 160 (S.D.N.Y. 1979)("there is unrefuted evidence that the patient is not truly a customer of the anesthesiologist"). Instead, they rely upon others—e.g., their individual surgeons and, ultimately, the hospital itself—both to make informed choices of ancillary care physicians for them, and, in effect, to vouch for the quality of the services provided.

The necessary nature of the ancillary services, combined with the lack of physician selection by the patient, has led courts to recognize the special legal obligation of the hospital to ensure the availability and quality of those services. *E.g., Dos Santos,* 684 F. 2d at 1354; *Capili,* 487 F. Supp. at 712 ("[t]hese are the services a hospital must guarantee as available to all patients . . . [;] [b]ecause the hospital patients do not select the physicians rendering these services and generally

do not even know the names or qualifications of these physicians, the hospital has a greater burden of responsibility in assuring the proper quality and quantity of such services"). *See also* HHS Medicare Conditions of Participation, 42 C.F.R. § 405.1011 *et seq.* (1977); Joint Commission on Accreditation of Hospitals ("JCAH"), *Accreditation Manual for Hospitals* (1982), for specific requirements imposed on hospitals for the provision of ancillary medical services.

b. Quality and Efficiency Benefits

Many hospitals have determined that, in light of their own individual circumstances and experiences, exclusive arrangements provide the most effective and often the *only* means to ensure both the continuous availability of medical services and the quality of those services. One essential characteristic of exclusive arrangements between hospitals and physicians is precisely that the physicians contractually guarantee the hospital twenty-four hour coverage of the subject service in return for the exclusive right to provide all such services at the hospital. Indeed, hospitals may find that they are unable to attract to their staffs anesthesiologists and other ancillary care physicians who are able to guarantee continuously available care unless those physicians are granted the exclusive right to provide all of the subject services at the hospital. Physicians cannot feasibly provide assurances of coverage or quality where departmental responsibilities are fragmented.

In the absence of a contractual guarantee of continuous coverage, a hospital is likely to experience situations where anesthesiologists, e.g., are unavailable for surgery either because of sickness, vacation, or time limitations. *See Capili*, 487 F. Supp. at 711, 712 (prior to contracting exclusively, hospital attempted to ensure coverage through "on call" services of anesthesiologists, which proved "inadequate to insure proper patient care"; JCAH annual review of hospital under "on call" arrangement indicated "deficiencies" in provision of anesthesia services). As specifically found by the district court in the

instant case, an exclusive arrangement assures the hospital twenty-four hour coverage of the subject service, 513 F. Supp. at 540; *see also, e.g., Dos Santos,* 684 F. 2d at 1351; *Capili,* 487 F. Supp. at 712, and thus assists the hospital both to ensure proper patient care and to avoid potential liability based on inadequate rendition of that care.

In addition, courts (including the district court below), commentators and hospitals have recognized that exclusive arrangements produce numerous other, specific patient care and efficiency-related benefits which may be unattainable except by use of an exclusive arrangement but which also are crucial to the hospital's ability to discharge its own responsibilities concerning the quality and availability of medical services. *See generally* M.R. Pollard & R.F. Leibenluft, *Antitrust and the Health Professions; Policy Planning Issues Paper* (Federal Trade Commission, 1981) [hereinafter cited as Pollard & Leibenluft]; Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?,* 26 St. Louis U. L. J. 535 (1982) [hereinafter cited as Foster]. In general, those benefits flow from the exclusive contract's specific provision for the unified responsibility and accountability of a limited number of physicians to the hospital's governing board for the quality of all services rendered, as well as the physicians' typical contractual responsibility for the complete management of the hospital department, including the provision of supervisory, training and administrative services essential to the most effective and efficient delivery of the subject service.

Among the many benefits resulting from an exclusive arrangement between a hospital and a physician group is the hospital's increased ability to monitor continuously the performance of the contracting physicians to ensure that medical quality standards are being met. *See, e.g.,* Pollard & Leibenluft, *supra,* at 97; Foster, *supra.* Also, the exclusive arrange-

ment serves to foster greater physician competence, due to increased specialization with attendant development of skills through repetition of specialized procedures. *Id.*

In addition, because the terms of exclusive arrangements typically are for short periods of time and/or terminable on short notice, a hospital dissatisfied with the performance of the contracting physicians can terminate the arrangement and contract with others. *Cf. Dos Santos,* 684 F.2d at 1354 (exclusive arrangements "may also serve to benefit competition among anesthesiology groups[,] ... encourag[ing] anesthesiologists to improve the quality of their services in order to obtain these contracts") (quoting the *district* court herein, 513 F. Supp. at 541); *Smith,* 518 F. Supp. 644 (rejecting physician group's antitrust challenge to exclusive contract, which was awarded to second group determined by hospital to be better qualified).

Further, caselaw emphasizes that exclusive arrangements facilitate improved scheduling in the use of facilities and support staff. *E.g., Capili,* 487 F. Supp. at 712 ("advantages of the exclusive arrangement [for provision of anesthesia services] ... included the efficient scheduling of surgery"). Procedures are done best, most reliably and most efficiently when access to facilities and equipment is planned in advance. Such planning typically is one of the specific contractual obligations of the physician group, and is simplified when coordinated through a single source. For example, a hospital that maintains an exclusive arrangement with an anesthesiology group secures thereby unified responsibility for the scheduling of use of the operating room, effectively minimizing the delays and conflicts that arise when a hospital must accommodate the personal scheduling wishes of multiple independent practitioners.

Exclusive arrangements also provide greater control and standardization of procedures, thereby allowing lower opera-

ting costs. *See, e.g., Smith,* 518 F. Supp. at 648 ("exclusive contract permits more control over standards, personnel and procedures"). More effective selection, use and maintenance of equipment also results. *See, e.g., Capili,* 487 F. Supp. at 712 ("advantages of the exclusive arrangement . . . included . . . the uniform selection and use of anesthesia equipment and gasses"). For example, the use of costly and sophisticated equipment by only one group minimizes the number of equipment breakdowns and facilitates recognition and remedy of malfunctions that do occur. Further, an exclusive arrangement directly facilitates improved work routines and teamwork because physicians both work consistently with and have a specific contractual obligation to supervise a particular group of nurses and technicians, whose services also are crucial to the effective and efficient delivery of the subject service. *See generally* Pollard & Leibenluft, *supra,* at 97; Foster, *supra.*

Finally, then, and as a result of the many benefits discussed above, the hospital is able to earn an enhanced reputation for excellence, thus enabling it to attract top flight physicians. *Id.* Given the increased willingness of courts to hold hospitals liable for negligently granting staff privileges to unqualified physicians, *see, e.g., Elam* v. *College Park Hospital,* 183 Cal. Rptr. 156 (Cal. App. 1982), this consideration is particularly important if the hospital is to minimize its vulnerability to malpractice litigation. In addition, however, the ability of the hospital to compete also is enhanced given that hospitals traditionally have competed on a non-price basis to provide the best *quality* of patient care. *E.g., Robinson,* 521 F. Supp. at 919 (closed staff system may promote competition among hospitals resulting in improved quality of patient care). *See Dos Santos,* 684 F. 2d at 1354 ("competition among the hospitals in the market [may be enhanced] by increasing the quality of medical care available") (quoting the decision of the *district* court herein, 513 F. Supp. at 541).

Thus, it is apparent that a hospital has a strong independent interest in maintaining exclusive arrangements with physicians. Demonstrable benefits obtained by the use of such arrangements directly assist the hospital to discharge its legal and professional obligation to its patients to ensure continuously available, high quality health care, and assist it to compete effectively with other hospitals.

III. The Decision of the Fifth Circuit Below, Applying the *Per Se* Standard of Antitrust Analysis to a Non-Price, Vertical Arrangement, Conflicts With Prior Decisions of This Court Which Prescribe the Circumstances Under Which Use of the *Per Se* Rule Is Appropriate.

a. In *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U. S. 36 (1977), this Court explained that "[*p*]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anticompetitive." *Id.* at 50. Recognizing that non-price, vertical restraints often have substantial redeeming virtues, such as the promotion of efficiency, protection from products liability claims and increased competition among firms at the manufacturing level, this Court held that, while it was possible that some vertical restraints might deserve *per se* treatment, any "departure from the rule of reason standard must be based upon demonstrable economic effect rather than . . . upon formalistic line drawing." *Id.* at 58-59.

The economic impact of the hospital's arrangement is similar to that presented in *Sylvania*, and has similar redeeming virtues. To increase the efficiency of providing medical services and to increase the quality of those services (for which the hospital bears legal responsibility), the hospital established what was, in effect, an exclusive distributorship for anesthesiology services which, when combined with other inputs, produced surgical procedures. By improperly delineating the hospital's relevant geographic market (see *infra*) to determine whether the hospital had sufficient economic power to justify *per se* analysis, and then by improperly invoking the *per se* rule, the

Fifth Circuit could not weigh properly the procompetitive effects of the hospital's arrangement against any purported anticompetitive effects. Rather, it engaged in the "formalistic line drawing" against which this Court has warned.

b. In *Broadcast Music, Inc.* v. *Columbia Broadcasting System,* 441 U. S. 1 (1979), this Court again discussed those circumstances in which a *per se* analysis is proper. Emphasizing that the crucial consideration is the conduct's impact on competition rather than its label, this Court held that the practice challenged there did not appear to be a "naked restrain[t] of trade with no purpose except stifling of competition," *id.* at 20 (quoting *White Motor Co.* v. *United States,* 372 U. S. 253, 263 (1963)), and thus that the *per se* rule did not apply. This Court explained that *per se* analysis is proper only where the practice "appears to be one that would always or almost always tend to restrict competition and decrease output," 441 U. S. at 19-20, rather than where the arrangement is "designed to increase economic efficiency and render markets more rather than less competitive." *Id.* (quoting *United States* v. *United States Gypsum Co.,* 438 U. S. 422, 441 n.16 (1978)).

The Fifth Circuit's error was in mechanically applying the tying label to the arrangement in question and then applying the *per se* rule. Had the court below first properly undertaken a threshold examination of the arrangement's economic effect, it would have found no restriction on the output of anesthesiology services because, as it held, the arrangement "did not lead to a higher charge for anesthesia services." 686 F. 2d at 291. Indeed, it is ironic that, according to the court below, the hospital violated the antitrust laws by an arrangement that both lowered costs and increased efficiency at the hospital, enhancing its status as an effective competitor.

c. Contrary to the position taken by the Fifth Circuit below, this Court's recent decision in *Arizona* v. *Maricopa County Medical Society,* 102 S. Ct. 2466 (1982), does not

mandate *per se* analysis here, even if the exclusive arrangement were viewed as a tying arrangement. That case focused on a horizontal agreement involving price. Non-price, vertical arrangements, in which the hospital has no incentive to undermine competition among physicians with whom it is not in competition, can generate significant procompetitive benefits that require consideration under a Rule of Reason standard.

Here, unlike in *Maricopa County*, the petitioner argues that its conduct beneficially affects the quality of service rendered at the hospital and thus the degree of competition in the market. Because the focus of competition among hospitals is on quality rather than price, *see, e.g., Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), actions by the hospital which can increase quality are particularly important and serve a competitive purpose.

The Fifth Circuit's holding that *Maricopa County* requires that certain non-price restraints be judged under the *per se* rule also conflicts directly with the Fourth Circuit's decision in *Hospital Building Co.* v. *Trustees of Rex Hospital*, 691 F. 2d 678 (4th Cir. 1982). There, the Fourth Circuit specifically distinguished between price and non-price restraints and refused to apply the *per se* rule to conduct which a jury had found to constitute a group boycott and market division. *Id.* at 684 n. 3. Thus, the instant case provides an excellent opportunity for this Court to clarify the scope of its *Maricopa County* decision.

IV. The Fifth Circuit Erred in Viewing the Facts of This Case as Constituting a Tying Arrangement

The Fifth Circuit below concluded without discussion that the instant case "deal[s] with two distinct services which a buyer should be able to obtain separately"—specifically, operating room and anesthesia services. 686 F. 2d at 289. However, operating rooms and anesthesia services cannot realistically be viewed as distinct and independently useful to the

patient, the availability of the latter being critical to the provision of the former. A patient admitted to a hospital for surgery depends upon the hospital and his or her individual surgeon to ensure the availability of anesthesia as well as numerous other services (e.g., anatomical pathology, blood room and various standby services) without which surgical procedures simply will not be performed in any modern hospital. Thus, only one product—surgical services—actually is being sold, and in selecting the anesthesiologist the hospital simply acts as a joint purchasing agent for its patients. Numerous decisions reject the Fifth Circuit's approach of defining a tying arrangement by looking for potentially severable components of what actually is a single service. *See, e.g., Times-Picayune Publishing Co.* v. *United States,* 345 U. S. 594 (1953).

V. The Fifth Circuit Erred in Finding a *Per Se* Violation, Relying on Erroneous Economic Analysis.

The tying characterization, as demonstrated above, is manifestly inappropriate to the economic arrangement in question. Moreover, the Fifth Circuit's holding that the arrangement is *per se* unlawful is erroneous because the hospital lacks appreciable economic power in an appropriately-defined relevant geographic market.

a. This Court has recognized many times that the major adverse economic impact from tying arrangements "is the wielding of monopolistic leverage; a seller exploits his dominant position in one market to expand his empire into the next." *Times-Picayune,* 345 U. S. at 611. *See also Fortner Enterprises, Inc.* v. *United States Steel Corp.,* 394 U. S. 495, 512 (1969) (White, J., dissenting). Use of leverage to expand market power in the tied product market is what distinguishes an unlawful tying arrangement from a legitimate exclusive dealing agreement and thus is the only factor that even arguably justifies a *per se* rather than a Rule of Reason analysis. On the other hand, "[i]f the product in the second market would be accepted anyway, because of its own merit, then, of course, no

leverage is involved." *Ungar* v. *Dunkin' Donuts of America, Inc.*, 531 F. 2d 1211, 1218 (3d Cir.), *cert. denied*, 429 U. S. 923 (1976).

b. In the instant case, the hospital did not engage in leveraging and in fact could not have done so. First, there is no indication in the record that patients objected to purchasing as a package the hospital's service and that of the anesthesiologist chosen by the hospital. This strongly suggests that no leverage was involved. Second, if the arrangement did not increase the price of anesthesiology services, as the Fifth Circuit held, output was not restricted and leverage was not exercised. *See generally* Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L. J. 19, 20 (1957).

Perhaps most importantly, however, the hospital clearly lacked the "appreciable economic power" in the market for the purported tying service, *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U. S. 610, 611-12 (1977), necessary to engage in leveraging and thus coerce patients into accepting both its service and that of the anesthesiologists chosen by it. As this Court stated in *Northern Pacific Railway Co.* v. *United States*, 356 U. S. 1, 6 (1958), proof of this power is crucial:

> [W]here the seller has no control or dominance over the tying product so that it does not represent an effectual weapon to pressure buyers into taking the tied item, any restraint of trade attributable to such tying arrangements would obviously be insignificant at most.

c. The crucial question in determining whether a seller has sufficient power in the market for the tying service to raise prices or coerce buyers into accepting other burdensome terms is "whether the seller has some advantage not shared by his competitors in the market for the tying product." *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U. S. 610, 620 (1977). The Fifth Circuit erroneously circumvented this question by improperly rejecting the district court's finding that the geographic market included at least the East Banks of

Jefferson and Orleans Parishes and concluding that the market was only the East Bank of Jefferson Parish. Even then, however, the court did not assess whether the hospital had some peculiar or unique advantage over others in the improperly defined market.

In delineating the geographic market, the court below erred in several significant respects. First, it assumed that the hospital industry is so different from others that all purchasers buy from the closest supplier. If this were true, every hospital would be a monopoly and competition among hospitals would be nonexistent—a suggestion totally divorced from reality. In reality, the primary influences on where a patient is hospitalized are the quality of care the facility offers and the facility suggested by the patient's physician, who is knowledgeable about that quality.

Most importantly, what little evidence there was with respect to geographic market showed that the proper relevant market is substantially larger than the East Bank of Jefferson Parish. The court's reliance on Louisiana law directing the hospital to provide care in the hospital district was misplaced because the statute provides no constraint to deter either East Jefferson residents from using other hospitals in New Orleans or residents from other areas of New Orleans from using East Jefferson Hospital. Moreover, as the Fifth Circuit explained, only thirty percent of patients from the court's purported market, the East Jefferson Area, used East Jefferson Hospital. Fully seventy percent used other hospitals in the metropolitan New Orleans area. It is highly likely, therefore, that an overwhelming number of East Jefferson residents are hospitalized in facilities outside of the East Jefferson Area. Those hospitals clearly would constrain East Jefferson Hospital's behavior, and the geographic market must include them and the areas that they serve. Of course, these hospitals would become even more attractive to patients residing in the East Jefferson Area if East Jefferson Hospital or the anesthesiology

group practicing there attempted to lower quality or raise prices.

The Fifth Circuit's opinion fails even to suggest East Jefferson Hospital's share of a properly defined market. If, however, as the Fifth Circuit agreed, there are twenty other hospitals in the area, that share must be extremely small; certainly it would be insufficient to permit leveraging by East Jefferson Hospital unless the hospital had some unique competitive advantage, a factor which the Fifth Circuit did not discuss.

d. The court below clearly erred in assessing the hospital's economic power and thus its ability to impose a tying arrangement. More importantly, its analysis of the relevant geographic market for hospital services conflicts with that of other courts examining the same issue. *See, e.g., Robinson* v. *Magovern,* 521 F. Supp. 842, 878-86 (W. D. Pa. 1981), *aff'd mem.,* 688 F. 2d 824 (3d Cir.), *cert. denied,* 103 S. Ct. 302 (1982). As the health care industry in general and hospitals in particular are subjected to increasing antitrust scrutiny, proper market delineation is crucial and deserves examination and clarification by this Court.

CONCLUSION

The economic environment of health care is changing through public and private policy initiatives. The direction of these changes is such that increased application of antitrust law to health care may be anticipated. Those in the health field believe that well-reasoned application of the law is imperative to avoid needless and harmful disruption of critical patient care arrangements. To this end, we respectfully request that this Court issue the writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

RICHARD L. EPSTEIN
ROBERT W. MCCANN
LINDA A. TOMASELLI
840 North Lake Shore Drive
Chicago, Illinois 60611
Attorneys for Amicus Curiae
American Hospital Association

Of Counsel:
H. ROBERT HALPER
JOHN J. MILES
O'CONNOR & HANNAN
1919 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
LAWRENCE A. MANSON
WOOD, LUCKSINGER & EPSTEIN
444 North Michigan Avenue
Chicago, Illinois 60611